Madison Brain Center

Name ________________________________ **Date __________**

Address____

Zip Code ________________

Email ____

Home Phone ____________________ **Cell _______________**

Age __________ **Birthdate_____________**

How did you hear about us? ____

MESSAGES: if we call you may we leave a message with someone else? Yes ___ No___
May we leave a message on: your home answering machine? Yes ___ No___ your cell phone? Yes ___ No___
Other instructions about leaving a message________________________________

Why are you seeking Neuro-feedback? Primary problem/goals that you'd like to improve

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How are the symptoms that you experience affecting the quality of your life? Describe how you feel, what you notice, how they affect your relationships, to-do list, goals, dreams, sleep. Etc. How often do they occur? Daily, Weekly, Monthly.

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Providers you've seen and/or or how have you coped with these symptoms or issues?

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Medicines you are currently taking, dose, frequency and reason prescribed?

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Over the counter Medicines, Vitamins and Supplements take – dose and frequency?

(who suggested)

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